IMAGES IN EMERGENCY MEDICINE

Aortic dissection: an *x* ray sign

A 55-year-old man, with a history of hypertension and smoking, presented with severe acute onset central chest pain, radiating through to the back and down to the umbilicus area of the abdomen. His blood pressure was 210/110 in both arms, peripheral pulses were normal, and there was no focal neurological sign. An electrocardiogram was normal. Chest *x* ray did not show obvious mediastinal widening, but incidentally the space between intimal calcification and the outer border of the aortic arch was >1 cm, a recognised radiological sign of aortic dissection (fig 1). Awareness of this is crucial. Troponin was normal but D-dimer was raised. A computed tomography scan confirmed aortic dissection type B, managed conservatively with intravenous labetolol and analgesia, with a good outcome.

S Gartland, D Sookur, H Lee
Wythenshawe Hospital, Southmoor Road, Wythenshawe, Manchester, UK

Correspondence to: S Gartland, Wythenshawe Hospital, Southmoor Road, Wythenshawe, Manchester M23 91T, UK; samgartland@yahoo.co.uk

doi: 10.1136/emj.2006.037010

Accepted for publication 31 March 2006

Figure 1 Chest *x* ray showing a recognised radiological sign of aortic dissection.

Calcium oxalate crystalluria

Figure 1 Calcium oxalate crystalluria.

A 42-year-old man presented with acute abdominal pain and nausea. The patient reported drinking about 650 ml of anti-freeze 24–36 h before presentation, in an attempt to commit suicide. Initial laboratory testing showed a pH of 7.25, an anion gap of 13 and an osmolar gap of 17. His blood urea nitrogen was 20 mg/dl and his creatinine concentration was 2.5 mg/dl. Microscopy of unspun urine under polarised light showed numerous clumps of calcium oxalate crystals, consistent with ethylene glycol toxicity (fig 1). Treatment was initiated with high-dose pyridoxine, thiamine and an ethanol drip owing to unavailability of fomepizole at our institution.[1] Over the next 9 days his creatinine peaked at 4.6 mg/dl, but gradually returned to normal without dialysis.

L Gaines
K H Waibel
Eisenhower Army Medical Center, Fort Gordon, Georgia, USA

Correspondence to: K H Waibel, Department of Medicine, Brooke Army Medical Center, Fort Sam, Houston, TX 78234, USA; kirk.waibel@se.amedd.army.mil

doi: 10.1136/emj.2006.037200

Accepted for publication 8 April 2006

REFERENCE

1 **Brent J**. Current management of ethylene glycol poisoning. *Drugs* 2001;**61**:979–88.